U.S. Army – Baylor University

Graduate Program in Healthcare Administration

Breaking the Code to Quality Improvement of Medical Report Translations

(A Retrospective Analysis)

A Graduate Management Project Submitted to the Program Director in Partial Fulfillment of Requirements for the Degree of Master's in Health Care Administration.

April 2004

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Report Documentation Page

Form Approved
OMB No. 0704-0188

1. REPORT DATE	2. REPORT TYPE	3. DATES COVERED
23 JUL 2004	**N/A**	**-**

4. TITLE AND SUBTITLE	5a. CONTRACT NUMBER
Breaking the Code to Quality Improvement of Medical Report Translations (A Retrospective Analysis)	5b. GRANT NUMBER
	5c. PROGRAM ELEMENT NUMBER
6. AUTHOR(S)	5d. PROJECT NUMBER
	5e. TASK NUMBER
	5f. WORK UNIT NUMBER
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) **67th CSH/WMEDDAC Unit# 26610 APO AE 09244**	8. PERFORMING ORGANIZATION REPORT NUMBER
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)	10. SPONSOR/MONITOR'S ACRONYM(S)
	11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION/AVAILABILITY STATEMENT
Approved for public release, distribution unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT

15. SUBJECT TERMS

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			
unclassified	**unclassified**	**unclassified**	**UU**	**53**	

Standard Form 298 (Rev. 8-98)
Prescribed by ANSI Std Z39-18

Acknowledgements

Several individuals have been extremely helpful assisting with the project. COL Clark and LTC Stewart were extremely helpful in providing focused guidance to initiate and establish my priority of work for this project. LTC Wilhite and MAJ Sproat have provided a thorough review of my progress, as well as intuitive suggestions for improving this project. Additionally, LTC Mulkey, (my reader) has been instrumental to the success of this project. LTC Mulkey suggested structuring the format of this topic into a private policy analysis. I would also like to thank SFC(P) Temple (NCOIC) and the staff of Patient Administration for their support and assistance on the translation project.

My wife, Bridgette, and sons, Jacob, Jackson and Alex have also been helpful, understanding and supportive during the course of this project.

Abstract

Over the past year, the 67th Combat Support Hospital/WMEDDAC has accumulated a backlog of over 4,000 pages of network provider medical reports awaiting translation. Throughout the Europe Regional Medical Command military medical treatment facilities have had varying degrees of difficulty with the timely translation of medical reports. However, at 4,000 pages, the 67th CSH/WMEDDAC has the greatest amount of accumulated medical reports awaiting translation services. The patient medical record is a vital component to all medical treatment procedures used by clinical staff as both a history and road map to care. The purpose of this Graduate Management Project (GMP) is to perform a retrospective analysis to objectively review the medical report translation program and identify obstacles impeding translation services. Additionally, a recommended course of action will be developed to improve translation services and minimize or eliminate medical report backlogs.

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INTRODUCTION

The Wuerzburg medical treatment facility (MTF) is one of three regional U.S. Army hospitals in Germany. Unique in its personnel structure, this MTF is a conglomerate organization consisting of the 67th Combat Support Hospital (CSH), as well as soldiers and civilians assigned to the medical treatment facility. Considered a relatively small 53 bed hospital, it has the enormous responsibility for providing health care to beneficiaries across the entire German State of Bavaria. This area is approximately 10,000 square miles and incorporates 10 outlying health clinics to assist in the delivery of care to 60,000 enrolled soldiers, civilians and family members. In association with the role of providing medical care to the community, the CSH has a medical support mission to 1st Infantry Division. This responsibility often requires the CSH to disengage operations at the medical treatment facility to perform quarterly training requirements or deployments for six months and sometimes longer.

Medical report translation is a mission essential function within the Europe Regional Medical Command (ERMC) and the 67th Combat Support Hospital (CSH)/Wuerzburg Medical Department Activity (WMEDDAC). The primary purpose of the service is to provide an English translation of medical reports generated by German host nation Preferred Provider Networks (PPN). Similar to the United States private health care sector, the German PPN compliments the military system and provides quality care with specialties that may not be available in remote locations. Clearly, the PPN delivers an equally high standard of health care

to U.S. military personnel and their families stationed overseas.

The capability for utilizing health services of the host nation medical system is provided via contract and memorandum of understanding (MOU) between ERMC MTFs and corresponding German health care providers in the local communities. Analogous to most Army procurements, the German provider network is the product of a service contract issued by the regional contracting office and managed through the TRICARE Europe Office (TEO). This service contract is intended to augment the health services capabilities of U.S. military medical treatment facilities responsible for supporting U.S. forces, employees and family members stationed throughout the European Theater.

In the case of the 67th CSH/WMEDDAC, utilization of the German host nation PPN is sometimes necessary when the treatment protocol for any given patient exceeds capacity or level of care provided at the hospital or its 10 outlying clinics. The extended family of outlying clinics provide basic health care services through primary care providers and support their installations with sick-call and physical exam services. Subsequently, throughout the course of delivering care, it is not uncommon for these clinics to utilize the advanced or specialized care of the PPN, in close proximity to their patients.

After receiving treatment from the host nation PPN the patients translated medical report becomes a critical component to future follow-up treatment at his or her respective military treatment facility (MTF). These medical reports are essential to the continuity of care and facilitate the decision making process

of clinical providers. The provider utilizes these translated medical reports as part of an overall evaluation of the patient's health status. The sense of urgency and significance of prompt translation and return of the translated medical report to the referring clinic cannot be overstated. In monitoring and facilitating the practice of translating medical reports, a balance score card performance metric of 60 days processing time has been established. This metric is in accordance with several regulations, policies and directives to include the following: WMEDDAC Policy Memorandum #40-509, Army Regulations 40-61 Medical Logistics Policies and Procedures, 25-50 Medical Correspondence, 340-21 Army Privacy Program, 400-2 The Modern Army Record Keeping System (MARKS), 25-55 Department of the Army Freedom of Information Act, 310-50 Authorized Abbreviations and Brevity Codes, 360-5 Army Public Affairs (Public Information), 40-2 Army Medical Treatment Facilities: General Administration, 380-5 Department of the Army Information Security Program and the units balanced score card metrics. However, the high volume of PPN medical reports and constraints of the contract have been obstacles to balanced score card compliance and quality review of these documents.

The regional translation service agreement is a requirements type contract with a commercial vendor. This contract specifies the vendor shall provide all personnel, equipment, tools, materials, supervision and other items and services necessary to produce translated medical reports for U.S. Medical Treatment Facilities and geographically isolated units within Germany,

France, Netherlands, Belgium, Italy, Spain, Turkey and Greece. The period of performance is 1 July 1999 through 30 June 2004 or more specifically a base year contract plus four one-year options, for a maximum of five years. Performance objectives include the routine translation of medical reports within 10 calendar days after receipt of the request/order. Contract specifications require documents to be a mirror image of the originals. This often results in excessive cost because unnecessary information is translated. Translations are required to be error free and all translators must be certified. The price schedule is according to lines per document. The maximum workload of the contractor is measured in pages per day with a limit of 100 pages per day. In the event more than 100 pages are received by the contractor in a single day, the contractor is required to notify the TRICARE European Office, Sembach, Germany to establish an acceptable delivery schedule.

Conditions Prompting The Study

The next logical question would be why? Why does the 67th CSH/WMEDDAC have such a large amount of untranslated medical reports waiting to be processed by the vendor? Since April of 2003, the 67th CSH/WMEDDAC gradually began accumulating large amounts of untranslated medical reports and by late Summer, early Fall 2003, this backlog reached a peak of 4,000 medical reports. However, prior to addressing the question of why, it is important to understand the context in which the 67th CSH/WMEDDAC supports and delivers health care. The population the 67th CSH/WMEDDAC serves is one of the largest soldier populations in the region.

It consists of approximately 60,000 beneficiaries, covering the entire German state of Bavaria, for a grand total of 10,000 square miles. These geographic characteristics and limited resources require the 67th CSH/WMEDDAC to frequently solicit medical services available on the local Preferred Provider Network (PPN). Among the Europe Regional Medical Command, the 67th CSH/WMEDDAC is the largest producer of medical reports requiring translation services. Over the course of normal operations in the 67th CSH/WMEDDAC catchment area, the MTF generates a translation workload of approximately 220 pages of medical reports a week or 46 pages per day. Surprisingly, however, the capacity of the regional contractor is a maximum of 100 pages per day for all MTFs in ERMC.

As previously stated, the translation of the 67th CSH/WMEDDAC routine medical reports is a contract provided service. The statement of work (SOW) is the framework for the standards or expectations of vendor performance. These contract guidelines clearly limit the amount of medical reports the contractor is required to process in a single day, but it also indicates that some type of action will occur between the contractor and the TRICARE Europe Office to process those additional pages of medical reports that exceed the 100th page in a day. In this particular case, however, it is important to note that once the 100th page of medical reports is received, any additional reports sent the same day will fall outside the vendor's contractual obligation to translate and return them within the required 10 days processing time.

The current process of translating medical records is managed among several areas at the MTF: The TRICARE Service Center Health Benefits Advisor, Patient Administration Division (PAD), and various clinic administrative staff. The process begins with a WMEDDAC beneficiary having a health problem (non-emergency/non-psychological). This patient is initially evaluated by his or her MTF primary care manager, who determines if treatment is available at the MTF. If care is not available, a consult stating the situation is put into the Composite Health Care System (CHCS). The Composite Health Care System is a fully integrated automated medical information system and is utilized by Department of Defense health care facilities around the world. It automates inpatient and outpatient medical information to manage patient appointments and scheduling of medical services such as radiology, pharmacy, laboratory, nursing and other clinical services.

Serving in the capacity of a health care coordinator, the Health Benefits Advisor (HBA) determines if prescribed care is authorized under TRICARE regulations and if so, an authorization is issued, and an appointment is made with the PPN to provide care. The patient is then provided with a claim form and normally authorized three to five visits for evaluation and treatment. If the patient is an active duty service member, approval is required by the Deputy Commander for Clinical Services or Deputy Commander of Outlying Health Clinics, depending upon whether he patient is from the internal hospital clinics or one of the outlying health clinics. After the patient is treated, the PPN

provider prepares a summary of the visit or treatment and sends a medical report to the respective HBA (Note: If the primary care manager is at the main hospital, the PPN medical report comes to the HBA representative at the hospital. However, if the patient’s primary care manager is at one of the outlying health clinics, the PPN medical report goes to that health clinic). The HBA then forwards the medical report to Patient Administration Division (PAD) for translation. The PPN referral process is described in Figure 1.

Functioning in the role of command and control, and contracting officer representative (COR), the PAD office manages the accountability, delivery and return of translated reports from the contractor, as well as payments to the contractor for rendered services. The COR has a critical role in monitoring the contractors' performance to assure compliance with the statement of work.

PPN Referral Flow Diagram

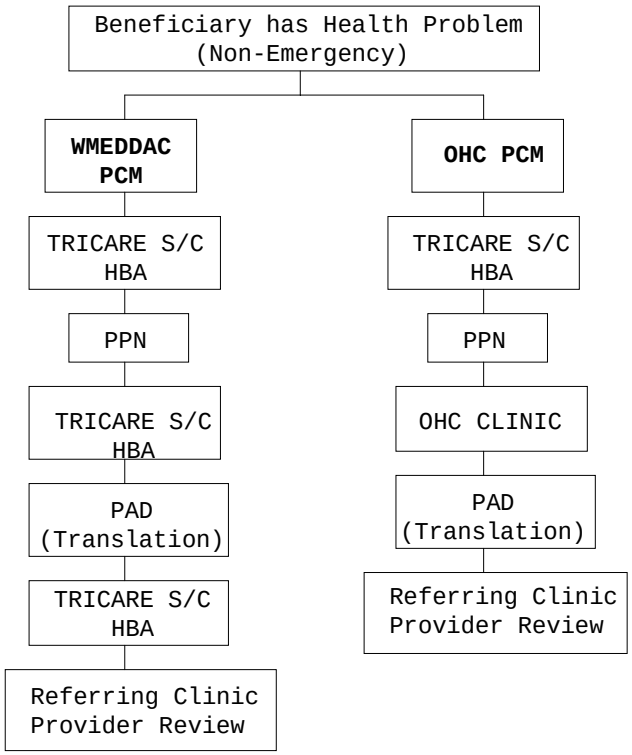

Figure 1. Depicts the activities involved in the management of PPN medical reports.

The COR evaluates and comments on any aspect of the contract and its performance, including problem areas and possible technical issues. The appointment of a COR is contract specific and involves explicit training provided by the Defense Logistics Agency (DLA). This training is conveniently offered online (www.faionline.com). Historically, the Chief of Patient Administration Division has served in the role of a COR for the translation contract. PAD operates as a central receiving point for all translation requests going out and translated reports coming back into the 67th CSH/WMEDDAC organization. This responsibility involves the requirement to verify patients on the translation request as entered in CHCS. The CHCS validation

ensures the translation request is for an enrolled or authorized Department of Defense Health Care beneficiary. After validating patient enrollment in CHCS, the PAD office then segregates the translation requests into priority categories requested by the referring clinic: Emergency (1-5 days completion time), Routine (no more than 10 days to complete) or Priority (not more than 60 days). The PAD office then proceeds to date and time stamp the receipt of the translation requests and records the action into a logbook for tracking. The last step in the central receiving process is to deliver emergency and priority translation requests to a team of translators employed by the 67th CSH/WMEDDAC. Routine requests for translation are forwarded to the contractor for processing.

A policy analysis is desirable due to the significant backlog of routine untranslated medical reports that have accumulated with the vendor over the past year. At one point this reached a level of 4,000 pages, near the end of fiscal year 2003. In turn, senior management of the hospital became extremely concerned regarding the potential negative impact on patient care. Likewise, the process of how medical reports get translated is also in need of further examination because translating is resource intensive in terms of cost, time and manpower. The present method of translation facilitates a high rate of resource consumption in an environment constrained by fiscal and personnel limitations. Additionally, the effect of timeliness on patient outcomes cannot be ignored. Further compounding the problem is the difficulty related to forecasting deployments in the U.S.

Army Europe Theater, which results in higher PPN utilization and greater competition among MTFs for vendor priority on translation requests. Many of these factors have facilitated the conditions and circumstances leading up to the problem of backlogged medical reports. The cause of the current backlog is attributed to the unexpected (real or perceived) poor performance of the regional commercial vendor. The inability to resolve vendor translation capacity problems and manage greater volumes of medical reports is indicative of systemic problems. Obviously, it is also counterintuitive to operate under such conditions for several years. The absence of any successful contract remedy action to adjust vendor performance to meet management objectives (i.e. Balance Score Card metric) is an indication of need for intervention.

Problem Statement

How can the 67th CSH/WMEDDAC expedite the current backlog of untranslated medical reports and ensure future contract compliance that is timely, of sufficient quality and predictable for clinicians supporting the 67th CSH/WMEDDAC catchment area? Implied within this problem is the need for a control mechanism to evaluate the quality or standard of care provided by the PPN. Clearly, the primary focus is how that process impacts the continuity of care for the patient. Furthermore, addressing the problem statement requires the close examination of work priorities, sequence of events and causal factors associated with producing a translated medical report from the network. The flow chart in figure 2 illustrates the complicated translation process

at the WMEDDAC. The strategy for addressing the problem involves a review of contract statement of work specifications, contract oversight/supervision and the contract selection process.

Translation Work Flow Diagram

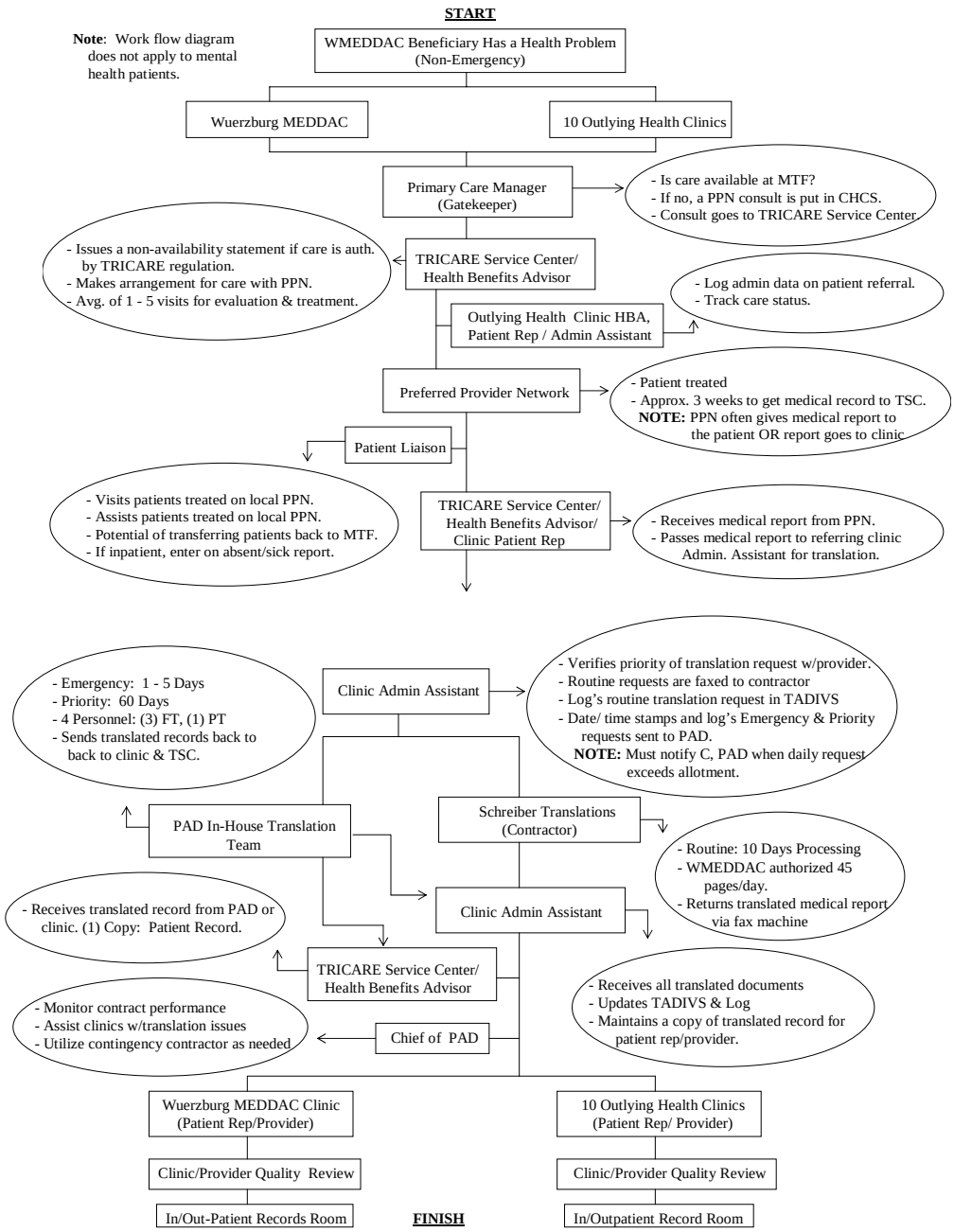

Figure 2. Illustrates the complex process of WMEDDAC medical report translations.

Literature Review

There are several studies that address the unique challenges presented by the requirement to perform language translations on medical reports. Much of this research is focused on the influence translation services have on the efficacy of treatment for non-English speaking patients. For example, in the study "From Meaning to Meaning," Noreen Esposito examines the impact of translation techniques on the collection and interpretation of non-English to English qualitative data, with the goal of offering suggestions to minimize threats to validity (Esposito, 2001). A common theme of the literature findings is the relationship between appropriate translation and interpretation services to positive treatment outcomes (Hatton & Webb, 1993). This theme is similar to the purpose of this analysis because the intent is to analyze the policy and facilitate responsive and predictable service that returns translated medical reports back to clinicians in a manner that promotes continuity of care. The significance of an accurately translated medical report in the patient diagnosis cannot be overemphasized. The medical record provides insight into the patient's ability to cope with a medical problem or the effects of a planned medical treatment, on a pre-existing health condition (Hatton & Webb, 1993). The patient medical record is an historical document of events leading up to medical treatment and subsequent outcomes of delivered care (Temple, 2002). Clinical staff regard the translated medical report as highly significant to subsequent medical care (Marshall, 1994). The ultimate goal of clinical

staff at any health care organization is to accurately diagnose and treat patients according to prescribed treatment or clinical practice guidelines (McLeod, 1996). These protocols or guidelines are applied in conjunction with information documented in a patient's medical record and used to map a course of treatment. The assurance of providing adequate medical services or making them available will increase the likelihood of patient compliance, healthy patient-provider relationships, and improved patient outcomes (McLeod, 1996). Additionally, operating in today's less structured primary care environment of advice nurses and e-health has resulted in providers having less control over patient information. Therefore, clinicians have become more dependent on patients to provide accurate histories and health care information, follow instructions, and administer and monitor their own treatments (McLeod, 1996). Thus, the significance of accurate patient medical records is even more important when administering patient care in a virtual doctor - patient setting. The concept of language translation is not a novelty in today's world of modern medicine, but there is no universally accepted definition of translation. For the purposes of this study proposal, translation will be defined as the transfer of meaning from one source language (German) to a target language (English). A translator or translation service is actually an interpreter or interpretation of a statement or conversation and, as such, requires the processing of vocabulary and grammatical structure of words, while considering the individual situation and overall cultural context of the source language (Esposito, 2001).

The prevalence of malpractice lawsuits against clinicians practicing medicine is a reality in today's health care environment. Communicating properly with patients has ethical, legal and professional implications for clinicians (Ledger, 2002). Accurate communication between patients and members of the medical team facilitates respect, and empowers the patient to make health care decisions (Ledger, 2003).

Purpose

The purpose of this project is to analyze the way the 67th CSH/WMEDDAC translation program functions in producing an English version of the PPN medical reports. An extensive analysis of the process will help reduce duplication of effort and inefficiencies, and will determine the most effective, efficient and equitable manner in which to provide timely translated medical reports. The primary objective of this analysis is to identify obstacles that are impeding the translation of medical reports and recommend a course of action to enhance translation services. Prompt translation and return of translated medical reports to referring providers is a management objective. The underlying incentive is that the more quickly the translated report is returned to a clinician, the more quickly the provider will be able to verify that appropriate, intended, quality care was delivered to the patient. For a manager to influence the efficiency and effectiveness of any aspect of a business operation, he/she must be able to apply a metric or standard of measurement that communicates an accurate assessment of performance. Peter Drucker asserts, if you cannot measure it, you

cannot manage it (Drucker, 2000). This analysis will not be limited to examining translation processes of the 67th CSH/WMEDDAC, but will focus primarily on the contract agreement for regional translation services. The main goal of this analysis is to identify problems with the regional translation contract in order to improve service to each MTF in ERMC. Contract compliance and provision of translation services that meet health care needs are the desired outcomes of this project.

METHODS AND PROCEDURES

Hypothesis: Translation of network provider medical reports, in accordance with established metrics of the Balance Score Card objective, and contract requirements will have a positive impact on the well being of the patient population. Given this hypothesis, this project utilizes the policy analysis approach to analyze and recommend a quality translation service for processing PPN medical reports. This project is intended to provide a value added review of the medical report translation process that will enhance and improve future operations. An integral part of this effort is the development of accurate contract specifications and enforcement of these terms. The tasks associated with meeting this goal include a background history and review of the current translation system and incorporation of applicable literature and analysis tools to improve the efficiency and effectiveness of the translation program. Additionally, there may be aspects of the current process that will enhance the development of an improved design to support the goal of eliminating backlog and improving turn around time of

translated medical reports. The policy analysis format utilized in this project was developed by Mr. Eugene Bardach, who is the author of the book, The Eight-Step Path of Policy Analysis. Mr. Bardach is a political scientist with a diverse background in both education and research. His extensive training and research is widely respected among the professions associated with public management and policy analysis and development. Eugene Bardach's eight step policy analysis involves defining the problem, assembling evidence, constructing alternatives, selecting criteria, projecting outcomes, confronting tradeoffs, deciding and telling your story (Bardach, 1996).

Step one, the problem itself is the basis for conducting the policy analysis. Step two, the collection of evidence involves the acquisition of data or information that can be transformed into evidence. The evidence influences the perceptions and beliefs about various aspects of the problem (Bardach, 1996). Constructing alternatives requires the development of possible solutions to be considered during the course of analyzing the process or policy (Bardach, 1996).

Criteria selection involves the selection of standards used to judge the goodness of anticipated policy or project outcomes. The evaluative criteria frequently used include efficiency, equity, effectiveness, freedom, security, empowerment of workers, legality and political acceptability (Bardach, 1996). Step five, projecting the outcomes of each selected alternative, depends on a thorough understanding of cause and effect relationships. Each forecasted outcome should explain the positive and negative

aspects of the alternative (Bardach, 1996).

Confronting the tradeoffs, step six, involves clarification of the positive and negative aspects of each policy alternative. Under certain conditions, one policy alternative is perceived to produce better outcomes in regard to all evaluation criteria. When there are no tradeoffs among alternatives, the situation is called dominance (Bardach, 1996).

Step seven, deciding, involves making the decision based upon the analysis. This involves the policy analyst placing him or herself in the position of the decision making party to determine if the evidence supports the proposed course of action (Bardach, 1996).

In the final step, telling your story, the decisive recommendation is made clear in a manner that takes all known objections or rebuttals into consideration. The goal is to convince the selection of an alternative over all others (Bardach, 1996).

In concert with the guidelines of Total Quality Management (TQM), the focus of this analysis is process improvement, not blaming individuals.

DISCUSSION

As Bardach states, The Eight-Step Path of Policy Analysis begins with defining the problem (Bardach, 1996).

Define The Problem

The backlog of untranslated medical reports has caused a disruption in the continuity of care for patients treated by host nation providers. The prolonged delay in translating PPN medical

reports is a serious problem that has the potential to have a negative impact on the diagnosis or treatment of patients with life threatening health conditions. The primary reason for the delay is rooted in the specifications of the translation contract and contract management.

The primary problem mentioned in the introduction is the backlog of untranslated medical reports (4,000 pages) that accumulated during previous years of translation operations and reached its peak at the end of fiscal year 2003. Obviously, extended delays in translation can have a negative impact on patient care. However, there is also the potential for adverse findings related to standards outlined in the Joint Commission on Accreditation of Hospital Organizations (HAS, 2004). Standard PC.15.30 states that when patients are transferred or discharged, appropriate information related to the care, treatment and services provided is exchanged with other service providers. The corresponding element of performance claims information shared should include the following, as appropriate to care, treatment and services provided: The reason for transfer or discharge, the patients' physical and psychosocial status, a summary of care and services provided and community resources or referrals provided to the patient (HAS, 2004).

Additionally, a factor influencing processing time, but not the main focus of this analysis, is clinic administrative procedures for handling patient record documents. In the absence of specific performance standards or standard operating procedure, there is a risk that translated medical reports will

be held in a clinic office for days before getting stored into the patient medical record.

Assemble Evidence

Four thousand backlogged medical reports by September 2003. By early September 2003, the amount of untranslated medical reports sent to the contractor and awaiting translation reached 4,000 pages. Although these reports were accounted for and their status known, they physically remained in the custody of the vendor and continued to age. Contributing to the backlog problem was the lack of real-time system communication or data mining capability to monitor the contractors' workload or that of clinics requesting translation services. Furthermore, in the absence of a centralized database, monitoring tool or grounded contract specifications, management had a very limited capability to recall or regulate the accumulation of excess medical reports on vendor hold for translation. In this particular case, it is clear to see that the absence of in-transit visibility precluded regional MTFs from knowing the point when the contractor received the 100th report of the day. Additionally, while the contract states in paragraph C(1)(dd) that, "In the event 100 plus pages are received on a single day, the contractor shall contact the TRICARE European Office located at Sembach, Germany to establish an acceptable delivery schedule," there is no documentation indicating attempts to arrange an "acceptable" delivery date was arranged with TEO on behalf of the 67th CSH/WMEDDAC backlog.

Poorly written contract specifications. The key to successful contract performance lies in the statement of need/work clauses

and provisions of the written contract. It is just as important to have a clear description of the statement of work as it is to have performance standards and guidelines that are understandable and reasonably enforceable. Moreover, it is absolutely critical to ensure that contract specifications minimize additional costs to customers operating within the limitations of programmed budgets. The translation services contract for fiscal year 2003 illustrates some examples of these types of challenges within the contract specifications. For instance, within the description of services, paragraph 1.2.2 states “Translation unit of billing will be by line of text translated. The estimated average yearly workload is based upon 54 lines per page of an 8.5 inch by 11 inch paper, using 12 point font pitch and 1 inch margins.” While these specifications may be impressive to read and demonstrate research effort and forecasting, it is also obvious that such a measure of billing, in the absence of automated support, would require the Contracting Office Representative (COR) to invest an enormous amount of time and effort to validate vendor billing or project costs on existing workload. Further complicating this billing method is the fact that many host nation providers don’t use the same size page or font pitch.

Some additional challenges are evident in the Service Delivery Summary that highlights performance objectives. In particular, the requirement to produce translated medical reports that are “mirror image” of the original PPN medical report resulted in unnecessary translation costs. This specification resulted in the purchase of numerous lines of translated information for which

there was no recurring requirement to translate (i.e. headings on medical report stationary containing clinic name, address, phone number and associated financial institutions). Given that translation cost per line includes letterhead, it is apparent these repetitive charges cost the hospital thousands of dollars over the course of a fiscal year. For example, on average, a PPN medical report heading involves four lines of translation and the 67th CSH/WMEDDAC processes approximately 200 pages a week. The price per line of routine translation is 55 cents. In this particular case, if this scenario involved 200 individual single page medical reports, it would cost the MTF $440 per week, $1,760 per month and $21,120 per year.

Another challenge is the obscurity within the contract regarding the definition of “acceptable delivery date,” as it pertains to the 100 page per day capacity of the vendor. This kind of ambiguity hinders efforts to remedy vendor performance or meet customer demand for translation service. Preferably, the desired outcome should involve promoting seamless customer service. The vendors’ volume limitation must have an actionable provision that articulates a contingency plan when vendor capacity is declared. The absence of these conditions may indicate a misunderstanding in respect to the potential impact on health care operations. Conceivably, had this been considered during solicitation, there might have been greater emphasis on developing an alternate course of action to manage medical reports beyond the translation ability of the vendor. Compounding the problem with contract specifications is the performance

standard for routine translations and the ensuing strategy of the vendor to meet this requirement. For instance, routine translations are required to be processed within a 10 calendar day turnaround time. Although this performance metric is a valid requirement, when combined with the 100 page per day restriction it results in the vendor pursuing a first-in, first-out management technique to meet contract specifications. More specifically, the adopted business practice for translating medical reports in excess of 100 pages is to set them aside indefinitely because there is no definition of “acceptable delivery date.”

Finally, the specifications, performance objectives and statement of need/work play a critical role when evaluating a vendor for demonstrated ability to perform to contract specifications. Therefore, if these qualifications are not thoroughly researched and correctly documented, the demonstrated performance will most likely not match the needs of the customer.

Lack of enforcement of existing specifications. Just as important as the specifications of the contract is oversight and enforcement of established terms and agreements. The recurring challenge within the translation contract has been the enforcement of the clause (C1dd) requiring the vendor to contact the TRICARE European Office and arrange an acceptable delivery schedule in the event 100 plus pages are received in a single day. This enforcement issue certainly had a negative impact on health care operations and customer satisfaction of the 67th CSH/WMEDDAC since most of the backlogged reports were over 6

months old by July 2003. The low priority on enforcement resulted in extended delays in quality review and follow-up care among clinicians and their patients. It also made it extremely difficult and many times impossible for the 67th CSH/WMEDDAC to meet the balance score card metric for translating PPN medical reports.

Unforeseen loophole precluding contract requirements. It appears evident that the contract statement of need was developed based upon data representing some known regional requirement and scope of work among military medical treatment facilities. However, there was obviously a miscalculation or inability to forecast changes in operational requirements that would impact the quantity of translation requests generated by an MTF over the course of a fiscal year. At a minimum, during the past five years regional operations increased medical mission requirements to support operations in Kosovo and now the Global War on Terror (GWOT). These missions reduce the amount of providers operating in the Wuerzburg area of responsibility and result in greater utilization of the provider network and increase requirements to translate medical reports. Evidently, deliberate planning for such contingency operations must account for deployed medical forces supporting these operations and the corresponding impact that results in increased referrals to the host nation provider network. Therefore, in the absence of data reflecting the rate of demand for translation requests, it is feasible that the 67th CSH/WMEDDAC actually produced a greater quantity of medical reports requiring translation. During the course of the

performance period it became evident the vendor did not have the resources to translate beyond the contract limitation of 100 pages per day. This was apparent early in service performance and assumed to be related to the vendors inability to “schedule an acceptable delivery date” for translation requests exceeding the 100 page limitation. Therefore, the identified contract loophole is the difference among the page limitation, customer demand and the vendors’ capacity to translate beyond the page ceiling. This loophole prevented management from taking corrective action and resulted in the large backlog of medical reports. In retrospect this contract loophole makes it apparent that the vendor was not delineated responsibility for “timely” translation of all submitted medical reports. While the wording within the contract states the vendor is responsible for contacting the TRICARE Europe Office to establish an “acceptable delivery date,” there is no definition of what “acceptable” equates to in units of time. Needless to say, while this loophole was a disadvantage to the customer, it remained an advantage to the vendor in the event of accusations regarding contract default.

Construct The Alternatives

The third step according to Bardach’s eight step policy analysis is to develop alternatives. Bardach considers alternatives to be policy options, intervention strategies or an alternate course of action having the potential to resolve the problem (Bardach, 1996). Additionally, he encourages a “take no action” approach as the first alternative in the process.

In considering the first alternative of taking no action, this

will obviously not reduce backlog accumulation or translate accumulated medical reports held in vendor custody. If present trends were allowed to continue undisturbed, the continuity gap in care for patients treated by host nation providers would continue to increase. Additionally, no action is no incentive for the vendor to cooperate or assist in the development of a course of action to process increased workload. Very simply, ignoring the problem will not make it go away and this option will only further disrupt health care services to patients treated on the network. Therefore, no action should be considered the most risky or non-productive alternative to select.

A second alternative is to refrain from awarding the final option period and pursue contract remedy or solicitation of revised statement of work. In doing so, the TRICARE Europe Office would have the opportunity to re-define specifications and requirements of the performance standards. Once validated, a revised solicitation is released for offers from industry. An acceptance of offer is based on demonstrated ability to meet all specifications of the contract.

A third alternative is the procurement of a contingency or alternate vendor to assist with translation workload that exceeds the capacity of the primary vendor. In this alternative, the primary contractor is responsible for meeting the performance objectives of all submitted medical reports. The contingency contractor is utilized by the primary contractor when workload capacity is reached. This alternative specifically addresses the concern regarding accumulated medical reports on hold at the

vendor work site.

Select The Criteria

Criteria selection is an important component of the analysis process because these standards are used to evaluate projected outcomes of each individual alternative. Bardach claims the evaluation criteria often used in an analysis include the following: efficiency, effectiveness, equality (equity, fairness, and justice), freedom, community, security, order, safety, and empowerment of workers (Bardach, 1996). He also suggests considering practical criteria including legality, improvability and political acceptability of an alternative (Bardach, 1996).

Bardach explains the criteria selected to judge the “goodness” of a projected policy outcome is for that purpose alone. The selected criteria are not intended to evaluate the alternatives themselves because there should not be an attempt to restrict the freedom for searching for alternatives that have the potential to produce desired outcomes (Bardach, 1996). Additionally, the best set of criteria is related to “solving the problem” to an acceptable level. Each potential outcome involves the judgment or evaluation regarding what is considered to be the most desirable result (Bardach, 1996). Therefore, criteria selection is the most important step for permitting values and philosophy to be brought into the analysis because criteria are evaluative standards used to judge the goodness of a projected outcome for each alternative (Bardach, 1996).

The criteria selected to evaluate alternatives to the translation contract backlog problem are taken from the book,

Principles and Methods of Quality Management in Health Care, by Donald Lighter and Douglas Fair. The alternatives for contract remedy will be evaluated using an analysis based on effectiveness, efficiency and equity of each outcome. In taking this approach it is important to understand the premise for initiating a quality improvement process. Quality improvement is a business philosophy that focuses on providing added value to services, customers and employees by increasing quality and reducing cost. The process does not stop upon reaching a management objective, but continues throughout the life cycle of the service (Lighter & Fair, 2000). Continuous quality improvement is a management paradigm that mandates persistent efforts to improve the quality of products and services produced by a firm. This method requires management to be system/process focused, instead of blaming individuals. The metrics used must be measurable and leadership must be committed to the process (Lighter & Fair, 2000). Edward Demming, an early pioneer in quality improvement of Japanese and American industry, developed 14 principles to guide quality improvement efforts. These principles have become the cornerstone of effective management and when adapted to health care, form the basis for an approach to implementing health care quality improvement. The 14 principles include stay in business, adapt to the new economic age, eliminate the need for inspection, reward quality, improve constantly, institute on-the-job training, help people and machines do a better job, drive out fear, break down barriers, eliminate slogans and quotas, restore pride of workmanship for

workers, restore pride of workmanship for managers, institute education and self improvement and make quality everyone's job (Lighter & Fair, 2000).

Numerical scores will be assigned to each alternative and will range from 0 (worst) to 10 (best). Scores will be subjectively assigned based upon my training and job experience in the field of logistics (15 years). See Score Grid in Appendix A.

My training includes the Army Basic Medical Logistics Management Course, the Medical Materiel Managers Course, Combined Logistics Officer Advance Course, Fundamentals of Contract Administration and Certification as a Contracting Officer Representative (COR).

My professional work experience related to contracting and logistics includes Division Medical Supply and Maintenance Officer, Property Book Officer (for a small MTF and large medical center), as well as Medical Supply Officer (Chief, Materiel Branch) of a small MTF and a large medical center.

Again, the designated alternatives are (1) take no action, (2) preclude award of final option period and seek remedy or solicitation of a revised statement of work, and (3) procurement of a contingency or alternate vendor (without any additional modifications to the statement of work or contract specifications).

Evaluation with a Focus on Effectiveness. As described in an Institute of Medicine Report (IOM), "Crossing the Quality Chasm," effectiveness involves providing products and services based upon scientific knowledge to all who could benefit and refrain from

providing services from those not likely to benefit. This means providing the best service based upon the latest technology and information, in the right proportion, to avoid under use and overuse respectively. Evaluating with a focus on effectiveness will aid the analysis in regard to maximum utilization of contracted translation services.

Effectiveness Evaluation of Alternative One. Taking no action or allowing present trends to continue undisturbed has no desirable impact for improving the effectiveness of the 67th CSH/WMEDDAC translation service. Tolerance of contract performance conditions without control mechanisms to translate backlogged medical reports is not a management objective. Additionally, with management fully aware of the translation dilemma, lack of action could easily be interpreted as informed consent by both the vendor and clinic customers. **SCORE – 0.**

Effectiveness Evaluation of Alternative Two. Precluding award of the last option period and pursuing contract remedy or solicitation of a revised statement of work is a viable alternative. This is an alternative that provides the contracting office with an opportunity to develop more accurate specifications and standards, delineate responsibilities, and provide a more effective service to customers. This course of action invites the opportunity to incorporate the clauses or performance conditions to prevent vendor capacity limitations that foster an accumulated backlog of medical reports. **SCORE–10.**

Effectiveness Evaluation of Alternative Three. Utilization of a contingency or alternate vendor is a practical consideration.

However, this option by itself, does not fully address the obscurity identified in the previously mentioned contract specifications. In terms of outcomes, it does attempt to address symptoms related to the problem of backlog translations, but without modifications to the statement of need/work and performance standard, it will not resolve problems with oversight, specifications and loopholes in the contract. **Score – 6.**

Evaluation with a Focus on Efficiency. Another criterion used to analyze alternatives is efficiency. As the IOM report, “Crossing the Quality Chasm” indicates, efficiency involves the process of avoiding waste, to include money, equipment, supplies, ideas, energy and services. Efficiency, in economic terms means to maximize net benefits through the use of an analysis to evaluate the relationship between resources and beneficial outcomes (Bardach, 1996).

Efficiency Evaluation of Alternative One. Take no action or let present conditions continue undisturbed does not facilitate the maximization of benefits for contracted translation services. At an annual cost of approximately $90,000 to the 67th CSH/WMEDDAC budget, the translation of PPN medical reports is considered to be a cost of doing health care business in Germany. However, as a customer, the expectation is that medical reports submitted to the vendor for translation will be managed efficiently, without a requirement for additional resources (money, time, logistics), other than those agreed upon in the contract. **Score – 0**.

Efficiency Evaluation of Alternative Two. Prohibiting the award of the fourth option period and pursuing contract remedy or solicitation of a revised statement of work provides the opportunity to initiate corrections on contract loopholes, nuances and enforcement challenges identified previously. Selecting this alternative creates the potential to assign the vendor responsibility for translating all medical reports upon their receipt. It also provides the chance to incorporate service options to allow MTFs/customers the flexibility to choose how they prefer to process their individual workload. This alternative supports the revision of vendor performance standards and restores responsible stewardship to minimize lost time associated with medical reports exceeding the daily limit of the contract. This may help facilitate translation of medical reports on hold at the vendor work site awaiting assignment of an "acceptable delivery date" for translation. **Score – 9**.

Efficiency Evaluation of Alternative Three. The procurement of a contingency contractor can potentially improve efficiencies with the translation of excess capacity medical reports. However, this alternative, by itself, does not address concerns mentioned regarding specifications, loopholes and oversight. In the absence of specific guidelines stating the procedures for the contractor when it obtains page capacity, there will not be an efficiency improvement. Under these circumstances, the contingency vendor would be less productive and require continuous management intervention (costly) to coordinate translation. The primary drawback of this alternative is that it resorts to additional

monetary and manpower (resource) investments without addressing the specifications or performance standards that govern the translation process. **Score – 5**.

Evaluation with a focus on Equity. The final area of alternative evaluation is equity. In the IOM report, “Crossing the Quality Chasm,” it states that equity involves the provision of services that do not vary based on demographic information such as gender, ethnicity, geographic location and socioeconomic status. Additionally, the term equity is synonymous with the term “fairness,” “justice,” “ethical” and “unbiased.” It is reasonable to assume that equity is a desirable goal and good for both business and health related interests.

Equity Evaluation of Alternative One. Take no action or let present trends continue undisturbed does nothing in the way of representing the interests of MTF clinicians and patients, who are stake holders in the translation program. That is to say there is a clear lack of fairness and consideration for the professional interests of providers and the wellness of patients. This alternative prohibits a fair, ethical and equitable outcome among 67th CSH/WMEDDAC management, clinicians, and most importantly patients. **Score – 0**.

Equity Evaluation of Alternative Two. Prohibiting the award of the fourth option period and pursuing remedy or a revised statement of work is a strategy that will promote equity in translation services. This course of action presents the opportunity to address all equity related concerns of ERMC medical treatment facilities and the health related concerns of

their patients. It affords the occasion for management (at ERMC MTFs and TRICARE Europe) to incorporate lessons learned from after action reports that highlight mistakes identified under the previous contract. It provides the chance to start fresh and ensure excellent translation services to all MTF's regardless of geographic location or level of care provided. **Score – 9**.

Equity Evaluation of Alternative Three. Procurement of an additional vendor is a course of action that is directly focused on increasing the equity of service to MTF customers. Regardless of whether an MTF produces the fewest PPN medical reports in the region or the greatest, this alternative promotes more equity through increased availability of translation services to all participants. The goal of greater translation capacity implies the desire to reduce processing time and improve service to clinicians and their patients. However, this process involves additional administrative actions associated with developing specifications, solicitation, performance demonstration and contract award. The corresponding result is that regional medical facilities are paying a higher cost for translations, while service deficiencies of the primary contractor remain unresolved. **Score - 7**

Project the Outcomes

Step five in Bardach's eight step path of analysis is to project the outcomes. As part of the review, outcomes or impacts are developed based upon the concerns of interested parties. These interests and concerns are incorporated into the development of outcomes or impacts for each alternative described

previously. Bardach claims that this is the hardest step in the analysis. He further states that many veteran policy analysts do not usually do this very well and in some cases analysts often try to avoid this step entirely (Bardach, 1996). According to Bardach positive and negative effects should be discussed when considering selection of an alternative. Many of the impacts and outcomes have already been discussed in the proposed alternatives, but a more thorough examination is beneficial.

Alternative One Projected Outcomes. Alternative one, “To take no action or let present trends continue undisturbed,” will produce several undesirable outcomes for clinical staff and patients of the 67th CSH/WMEDDAC. The backlog of untranslated medical reports would not get resolved and would continue to grow. This would have a negative impact on continuity of care delivered to patients who receive treatment from the provider network. Most primary care managers will not be able to evaluate PPN medical treatments without a translated medical report. Aside from the fact that there is no benefit to this course of action, the greatest concern among health care managers is that this course of action is an unethical alternative because it completely ignores all patient wellness concerns.

However, from the perspective of the vendor, taking no action and letting present trends continue would likely be considered a favorable course of action. This would not have any negative impact on the vendor because business operations would continue undisturbed, with no disruption to workload and no impetus to deal with workload accumulation (medical reports) awaiting

translation.

Alternative Two Projected Outcomes. Alternative two, “Preclude award of the final option period and pursue contract remedy or revised statement of work,” will require a significant investment of time and resources on the part of the TRICARE Europe Office, but will greatly improve services to medical treatment facilities within the ERMC area of responsibility. The TRICARE Europe office will generate a translation contract with clearly delineated responsibilities, customer service options and improved services that enable MTFs to meet the health care needs of their patients. A significant focus will be placed on reducing costs to individual MTFs, while improving the quality of translation services to the region.

This course of action will be the impetus for translation process reviews at each medical treatment facility. MTFs will examine procedures and time intervals at each stage of the translation process. Greater efficiencies and performance improvement will be sought in areas under the direct control of MTFs. From the vendors’ perspective, this alternative would have a negative impact on revenue in the event that a revised statement of work and re-solicitation results in a disqualification. Additionally, the assumption is the vendor will protest any work stoppage related to remedy actions and this could potentially result in lengthy litigation and additional costs to the government.

Likewise, the government normally prefers to avoid a work stoppage and or litigation associated with contract disputes

because these types of actions incur additional costs to the government (J.C. Pastino, personal communication, July 1, 2004). Depending on the size and cost of a contract a work stoppage initiated by the servicing contractor may result in removal action by the government. However, when the government enters into a contract with vendors owned by local nationals or employing local national employees' extreme caution is exercised, due to the complex rules and legal requirements of employment (R. Wolf, personal communication, July 1, 2004).

Alternative Three Projected Outcomes. Alternative three, "Procurement of a contingency or alternate vendor," will serve to expand the capacity to translate beyond the production constraints of the primary vendor. However, increases to cost and translation processing time (beyond original performance objectives) are anticipated for routine medical reports. This is due to the fact that more handling and administrative actions will be required to transfer medical reports between the two vendors before the translated report is returned to the customer.

This alternative will reduce the chances of future vendor backlog, but performance improvement will be negligible unless certain standards and criteria are addressed in the current statement of work. This alternative, by itself, will result in a complicated process and potentially make it more difficult to maintain accountability of the medical reports. Additionally, the more handling steps incorporated into the translation method, the greater the potential for violating regulations and therefore the greater the requirement for management intervention.

From an ethical perspective the intention is honorable, but the outcome is not likely to resolve many of the concerns related to contract loopholes, poor specifications and problems with contract oversight. These additional steps require additional time and this is likely to have a negative impact on patient care.

In the process of determining one course of action over another and the associated cost, the government seeks to maintain “honest broker status” in these situations. Unless an illegal or immoral activity is identified, it is very unlikely that the government will pursue litigation. Furthermore, the U.S. Government is not interested in any negative publicity loss of good will) associated with legal action against a local national vendor (R. Wolf, personal communication, July 1, 2004).

Confront The Tradeoffs

Step six in the analysis is “Confront the tradeoffs.” Bardach explains that occasionally one of the policy alternatives considered is thought to produce better outcomes in regard to all evaluation criteria when compared to the other alternatives (Bardach, 1996). If this is the case, there are no tradeoffs between the alternatives and the most favorable alternative is labeled “dominant.” The more likely situation, however, is that no single alternative is clearly the best, so there must be a deliberate effort to clarify tradeoffs among possible outcomes of several alternatives. Often the most common tradeoff is involved with money and a good or service provided to a customer (Bardach, 1996).

In this particular case, dominance is attained by alternative number two. Based upon evaluation results among efficiency, effectiveness, equity and projected outcomes, the alternative with the most favorable result is produced by alternative number two. Alternative number two demonstrates the potential for better outcomes that are most closely aligned to management goals.

Additionally, the government is not interested in the potentially high cost of litigation and work stoppage. The absence of historical data describing such costs indicates this course of action is usually undesirable and the risk of controversy is high (R. Wolfe, personal communication, July 1, 2004). The government prefers to resolve contract discrepancies at the lowest levels (Contracting Office Representative and Vendor) in the organization to minimize cost (J.C. Pastino, personal communication, July 1, 2004). Historically speaking, the likelihood of a contractor initiating litigation is higher when additional contractors are acquired to perform like services or a single workload is shared among separate contractors (R. Wolf, personal communication, July 1, 2004). Therefore, this alternative is less attractive, due to the potential of litigation and negative publicity.

Decide

Step seven of the analysis is “Decide.” Bardach explains that this step is designed to serve as a check on how well the analysis has been developed to this point. The analyst places himself or herself in the position of the decision maker and decides on the basis of the presented analysis. If this is

apparently difficult, then tradeoffs may not have been sufficiently clarified or serious implications have not been explained. Difficulty in decision making is also frequently linked to unclear cost estimates or emerging problems that have not been fully explored (Bardach, 1996). Additionally, a decision matrix is a valuable tool that can assist managers in the decision making process. The decision matrix utilized in this analysis will be based on weighted criteria of effectiveness, efficiency and equity. Effectiveness is the most important criteria, with efficiency and equity sharing an equal amount of decision weight. See decision matrix located in Appendix B.

In the event of a dominance situation with alternative number two, it is essential that the 67th CSH/WMEDDAC partner with TEO and regional MTFs to ensure performance standards and specifications are comprehensive and inclusive of the unique operational requirements of the facilities serviced by this translation contract. It is this specific point in the journey where Deming’s fourteen principles of quality improvement play a key role in improving the quality of the translation services. Toward this goal, communication barriers must be eliminated to facilitate discussions on contract specifications, concerns regarding management oversight (i.e. Balance Score Card) or contract enforcement, and patient wellness or privacy issues. It is equally important to incorporate principle number seven which is helping people and automated systems do a better job. More emphasis is required in the area of incorporating automation support to help eliminate manual tasks associated with tracking,

forecasting, estimating and administratively managing translations. Additionally, after a difficult two years filled with frustration and fatigue, it is important to restore pride in workmanship among the workforce and management. Then perhaps most importantly, the success in transforming and improving the translation program is associated with everyone being involved in the process. Therefore, quality must be incorporated into every ones' job.

On the journey toward quality improvement of hospital translation services, administrative managers of the 67th CSH/WMEDDAC must evaluate the risk of continuing to allow medical reports to grow beyond 4,000 pages of backlog. In the absence of corrective action from the contracting office representative (COR), the priority of work for patient administration shifts to course of action development to expedite translation services. In doing so, coordination for the systematic recovery of accumulated medical reports held at the vendor work site becomes a primary objective. Upon retrieval, local purchases had to be initiated with other commercial translation vendors to prevent further accumulation and waiting time. The main obstacle identified is associated with reducing medical report backlog, while simultaneously processing incoming translation requests. In preparation for initiating business practices, under a new contract, the intuitive decision to translate 4,000 records of backlog with a sub-contractor paved the way for a successful start in quality improvement.

Tell Your Story

The final step in the analysis is “Tell your story.” As Bardach states, after completing the previous seven steps of the analysis the process has resulted in refinement of the problem definition, reconsideration of alternatives and criteria, as well as reevaluation of projections, outcomes and tradeoffs. Now having reached this point, it is time to tell the story (Bardach, 1996).

In response to the requirements to meet the health care needs of the supported population, it is essential for the 67th CSH/WMEDDAC to support and participate in the implementation of the second alternative. As a major stakeholder, beneficiary and large producer of PPN medical reports needing translation, it is imperative that the 67th CSH/WMEDDAC remain actively engaged in the quality and performance improvement of translation services. The most dangerous course of action would be to sit on the sidelines and allow much needed contract revisions and performance metrics to go un-validated. Initial implementation success depends on 67th CSH/WMEDDAC remaining engaged with the TRICARE Europe Office and customers throughout the entire footprint.

Having made the decision to participate in the new regional translation contract, the incorporation of lessons learned suggests the need to shift business practices from a centralized program (under Patient Administration), to a decentralized system (individual clinic management). This will enable clinic customers to have greater visibility and control of their translated medical reports. It will also reduce excessive handling and

improve processing time of translated medical reports. The associated implied task involves the education and training of clinic administrative personnel on new business practices (i.e. internet order entry and receipt processing), automation tools and new specifications and performance standards to ensure customers understand the guidelines and boundaries of vendor services. It is also extremely important to ensure that customers (clinics) have the necessary equipment and resources in place prior to initiation of a new contract service (i.e. fax machines, phone line access). If these tasks are ignored or given low priority they often result in self imposed obstacles that preclude a smooth transition.

It is also important to note that contract award is solely managed by the Contracting Office. While the customer (MTF/TEO) is responsible for submitting requirements to the Contracting Office, customers are usually not part of the final negotiations developed through solicitation and request for proposal among the Contracting Office and potential vendor bids. In the absence of service recipients/customers, there is a greater potential of awarding a contract that does not meet the needs of the customer. In hind sight, the cause of the problem associated with this service contract and others like it appears to be the absence of accurate specifications and requirements. These types of obstacles are often overcome through the inclusion of key personnel who manage these services on a daily basis. In many cases, these are technicians and non-management personnel who know all the details of required services.

CONCLUSIONS AND RECOMMENDATIONS

As mentioned previously, the purpose of this GMP is to objectively analyze the 67th CSH/WMEDDAC translation program and identify obstacles impeding translation services. In support of that effort, I have determined the primary obstacle precluding translation services is the contract agreement itself. The absences of accurate specifications are most likely due to the exclusion of customer representatives who are the recipients of these services. This knowledge base and unique requirements of medical treatment facilities were not accurately documented in the solicitation process. Operating under the conditions of narrowly defined specifications, contract loopholes and corresponding difficulties with enforcing standards has resulted in the accumulation of a large backlog of untranslated medical reports.

In consideration of associated tradeoffs there is no benefit to the government initiating or encouraging litigation or work stoppage, due to additional costs and undesirable negative publicity among the local national population. Historical experience indicates the acquisition of sub-contractors to improve work site productivity results in a greater potential for costly litigation and controversy. Therefore, I have determined the prudent course of action to resolve the problem requires precluding award of the final option period and pursuit of solicitation and award of a revised statement of work. In determining this alternative as the most prudent way to support the 67th CSH/WMEDDAC translation program and prevent future

backlog, my job involved leading the transition effort in close coordination with the TRICARE Europe Office and supported clinic customers.

After completing all the preparation and tasks associated with the transition to a new translation vendor, management oversight and custody of the 67th CSH/WMEDDAC translation program should be returned to the Chief, Patient Administration by June 2004.

Appendix A – Scoring Grid

Grading Criterion	**Alternative One**	**Alternative Two**	**Alternative Three**
Effectiveness	0	10	6
Efficiency	0	9	5
Equity	0	9	7
Avg Score	0	9. 33	6

Appendix B - Decision Matrix

Criteria	Weight	Alternative 1	Alternative 2	Alternative 3
Effectiveness	3	(3) 0	(3) 10	(3) 6
Efficiency	2	(2) 0	(2) 9	(2) 5
Equity	2	(2) 0	(2) 9	(2) 7
Weighted Total		0	66	42

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